City of Bloomington
Housing & Neighborhood Development ——— **349-3401**
401 N. Morton ——— **349-3420**
P.O. Box 100
Bloomington, IN 47402 **Fax:** **349-3582**

Information Sheet

Social Service Funding Applications for
FY 2019 Community Development Block Grant Program
Fiscal Year June 2019 to May 2020

Letter of Intent is due October 12, 2018 by 4:00 p.m.
and
Application is due December 3, 2018 by 4:00 p.m.

in the Housing & Neighborhood Development Department

General Instructions:

1. All applications must be typed. Font size shall be at least 12 points.
2. Please respond to each section of the application as clearly and concisely as possible.
3. Please confine your responses to the space provided and provide both narrative and quantitative information in describing your organization/agency and the program for which funding is being sought. Do not attach additional sheets**,** except requested financial information.
4. Include your DUNS NUMBER on your application.
5. **Submit the original and <u>10 copies</u> of the completed application.**
6. All applications must be received by the due date. **LATE APPLICATIONS WILL NOT BE ACCEPTED.**

Funding Requirements:

1. In accordance with Federal law, to be considered for funding, the agency must have an affirmative action plan, be incorporated, have an accounting system compatible with Federal Regulations, and eliminate any provision or practices that discriminate or has the effect of

discriminating. Please turn in your affirmative action plan to the City of Bloomington Human Rights Department prior to the release of any funding. For assistance, please contact Human Rights at 349-3429.

2. Agencies will need to supply HAND with a copy of the most recent Audit, including the Management Letter, prior to the release of any funding. If you are applying for both Social Service and Physical Improvement funds, you need only supply one copy.

3. Only one application for funding per agency for Social Services will be accepted.

4. Community Development Block Grant funds must be used to provide services to income eligible City of Bloomington residents only. Please refer to the CDBG Program Guidelines for Determining Eligibility to ensure that your program can adhere to eligibility requirements.

5. Requests for less than $5,000.00 will not be considered. Maximum request considered is $25,000.00.

6. Agencies funded will be required to provide program/client data as required by HUD including monthly program statistics from June 1, 2019 to May 31, 2020.

7. Agency must be registered with System for Award Management at the time of submitting an application and keep the registration up to date prior to the release of any funds. See https://www.sam.gov

Application Instructions:

Question 1 – Organization/Agency History and Goals: This question is related to your agency, not the program for which you are requesting funding. Describe your agency, the type of programs your agency administers, the type of clientele provided services under those programs, how long has the agency provided services within the community, and the size of the agency in terms of employees.

Question 2 – Activities: Please briefly describe activities to be completed under this grant. Please be concise and confine your answer to the space provided. Do not use additional space.

Question 3 – Program Need: Your discussion should address how the program serves the needs of the community and its residents, how this need is quantified and documented by citing relevant data. Utilizing the Consolidated Plan 2015-2019 for the City of Bloomington, identify the public service category of your program and the priority need of this category. If applicable address how your program fits into the anti-poverty strategy (p. 108) or other goals and objectives outlined in the Consolidated Plan. Include your organization's capacity to successfully implement this program and why your organization needs financial assistance to implement this program. When applicable, include results achieved as a result of previous CDBG funding.

Question 4 – Evaluation Methodology/Outcome Measurement:

a. Tell us about your program goal(s).
b. Describe your evaluation tool for this program.

c. Tell us about the data you collected using your evaluation tool in 2017.
d. Tell us what your program benchmarks are.
e. Tell us about the results of your data collection.
f. Did you make any changes to your program based on your evaluation? If so, please describe.

Question 5 – Client Data:

Part I. Client History:

1. Please tell us how many clients you served for LAST program year between June 1, 2017 and May 31, 2018.
    a. What percent were city residents.
    b. What percent were CDBG eligible based on the 2017 income guidelines (if you were a CDBG recipient that fiscal year, you have this information from your monthly status reports).
2. Please tell us how many clients you estimate you will serve for THIS current program year between June 1, 2018 and May 31, 2019.
    a. What percent will be city residents.
    b. What percent will be CDBG eligible.

Part II. Proposed Level of Activity:

1. Estimate how many clients you will serve for NEXT program year June 1, 2019 to May 31, 2020, including non-CDBG eligible.
    a. What percent do you estimate will be city residents.
    b. What percent do you estimate will be city residents and CDBG eligible.
    c. Of the city clients, what percent do you estimate will be low-moderate income based on the supplied chart.
    d. Of the city clients, what percent do you estimate will be low income based on the supplied chart.
    e. Of the city clients, what percent do you estimate will be extremely low income based on the supplied chart.
    f. Of the city clients, what percent do you estimate will be female head of household as defined as a single adult female with dependent children.
2. Tell us how these estimates compare to your last year's (June 2017 to May 2018) actual client counts.
3. Tell us your average per client cost for your program. How much does it cost for you to serve one client.
4. Please tell us how you calculated this amount.

Question 6 – Budget Information: Self-explanatory.

Question 7 – Previous Effort: **NEW PROGRAMS ONLY.** You do not need to answer this question if you have received CDBG funding in the past year.

Question 8 – Program Budget: Fill out the budget worksheet showing FY 2017, FY 2018 and proposed FY 2019 budgets. Equipment purchases are not an eligible CDBG expense. In the

column titled *Amount of CDBG funds per line item*, please tell us how much you expect CDBG to pay of each line item.

Question 9 – List all sources of income . . . : Please list all of the sources of income you have for THIS program for the fiscal years designated.

Question 10 – List other grants . . . : Please list all of the funds your agency will apply for that will contribute to the cost of running THIS program. FY 2018 and FY 2019.

Question 11 – List any fundraising . . . : Please list all fundraising activities for THIS program. You may also want to include fundraising activities that are very well known that are used for other programs and explain. June 1, 2017 to May 31, 2018.

Question 12 – List any current fundraising . . . : Please list any current or future fundraising activities your agency is/will be undertaking for THIS program. June 1, 2018 to May 31, 2019.

Question 13 – List all staff . . . : Please list all staff for THIS program by title, not name. Please indicate full time (FT) or part time (PT), how many hours per week is charged to this program by this staff member, the amount of salary charged to this program for those hours, and whether or not any portion of this will be covered by CDBG funds.

CDBG Program Guidelines for Determining Eligibility

An eligible social service program activity must be run by a 501(c)3 organization or a governmental entity. It also must primarily benefit low- and moderate-income households (see Income Guidelines below) that reside within the jurisdiction of the City of Bloomington.

The activity must meet one of the following qualifying criteria:

a) The activity must exclusively serve a household in any one or a combination of categories generally presumed to be principally low and moderate income: abused children, battered spouses, elderly persons, adults meeting the Bureau of Census's definition of "severely disabled", homeless persons, illiterate adults, persons living with AIDS, and migrant farm workers; or
b) Information must be required on household size and income to document that at least 51 percent of the clientele are persons whose household income does not exceed low- and moderate-income limits; or
c) The activity must have income eligibility requirements that limit the activity exclusively to low- and moderate-income households; or
d) The activities must be of such nature and in such location that it may be reasonably concluded that the activity's clientele will primarily be low- and moderate-income persons.

For Criteria b) or c) above, the following lists options to meet the household size and income documentation requirements. This is in addition to this information being self-reported by the household on an intake form, application, or CDBG Client Information Form for the service:

i. Verification of public housing residency (i.e. Crestmont)
ii. Verification of Housing Choice Voucher (Sect. 8) assistance
iii. Copy of TANF or food stamp card or other benefit program
iv. Copy of two month's worth of pay check stubs
v. Copy of Social Security Benefit Amount letter or Social Security Verification form (see attached)
vi. Employment Verification form (see attached)
vii. Copies of ***signed*** federal or state tax forms or print out from IRS or Department of Revenue regarding last year's tax forms
viii. Copies of W2's

The following are the **reporting requirements** for all programs funded with CDBG:

1. Collect a CDBG Client Information Form (or equivalent) from all households that receive or participate in the service being provided.
2. On a monthly basis during the CDBG Program Year, provide an unduplicated count of clients who are city residents broken down by:
    b) Race (see attached information on racial categories).
    c) Female Head of Household defined as adult female with no male significant other ***with*** dependents.
    d) Income at or below 30% area median income; between 30-50% area median income; and between 50-80% area median income (see Income Guidelines below)
    e) Client Profile Reports (see sample below) must be filed monthly with claims.

f) If you serve other agencies, each agency located in the city limits must provide your agency with unduplicated client count by income, race, and Female Head of Household.

Current Income Guidelines (effective 06/01/2018):

	1 Person	2 Persons	3 Persons	4 Persons	5 Persons	6 Persons	7 Persons	8 Persons
30% of Median Income	$14,600	$16,700	$18,800	$20,850	$22,550	$24,200	$25,900	$27,550
50% of Median Income	$24,350	$27,800	$31,300	$34,750	$37,550	$40,350	$43,100	$45,900
<80% of Median Income	$38,950	$44,500	$50,050	$55,600	$60,050	$64,500	$68,950	$73,400

Sample Monthly Client Profile Report:

Category	**Total *NEW* Clients Served Program Year-to-Date (UNDUPLICATED COUNT)**	
At or below 30% AMI		
Between 30 – 50% AMI		
Between 50 – 80% AMI		
Above 80% AMI		
Total		
Racial Categories/Ethnic Groups	**Total served**	**Of total served, the total that are Hispanic**
White		
Black/African American		
Asian		
American Indian/Alaskan Native		
Native Hawaiian/Other Pacific Islander		
American Indian/Alaskan Native & White		
Asian & White		
Black/African American & White		
American Indian/Alaskan Native & Black/African American		
Other/Multi-racial		
Totals		
Female Head of Household		

Verification of Social Security Benefits

The person identified below has requested assistance through _____. The individual has authorized your release of the requested information. The information you provide will be used only for the purpose of determining the family's eligibility for this program. We are required to complete our verification process in a short time period and would appreciate your prompt response. A self-addressed envelope has been included for your convenience. If you have any questions, please feel free to contact _____, at _____. Thank you.

Part I. Applicant Information (To be completed by applicant)

Name of Applicant: _____ SSN:_____

Address of Applicant: _____

_____

Part II. Social Security Data (To be completed by Agency)

Client Name: _____ Date of Birth: _____

Monthly Payments from this Agency:

Gross Monthly $_____

Supplemental Security Income $_____

Other (Specify) _____ $_____

_____ $_____

Total Amount Received Monthly: $_____

Start Date: _____

Closing Date: _____

Do you expect any change in payments in the near future? o Yes o No

If yes, please explain.

Additional Comments: (e.g., any special situations, etc.)

Completed by:

Name: _____

Title: _____

Signature: _____

Date: _____

Tele. No.: _____

Warning: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.

Verification of Employment

The person identified below has requested assistance through _____. The individual has authorized your release of the requested information. The information you provide will be used only for the purpose of determining the family's eligibility for this program. We are required to complete our verification process in a short time period and would appreciate your prompt response. A self-addressed envelope has been included for your convenience. If you have any questions, please feel free to contact _____, at _____. Thank you.

Part I. Applicant Information (To be completed by applicant)

Name of Applicant _____

Address of Applicant _____

_____

Part II. Employer Information (To be completed by applicant)

Name of Employer _____

Address of Employer _____

_____

Part III. Employment Information (To be completed by employer)

1. Date of Employment: _____ Position/Occupation: _____
2. Date of Termination (if applicable): _____
3. Current Rate of Regular Pay $_____ per _____ (hour, week, month, year, etc.)
4. Current Rate of Overtime Pay $_____ per _____ (hour, week, month, year, etc.)
5. Do you anticipate any change in the employee rate of pay in the near future?
   o Yes o No. If yes: Revised Rate _____ Effective Date _____
6. Number of hours/weeks employee normally works _____
7. Do you anticipate any change in the number of hours the employee works: o Yes o No
   If yes, explain under #14 below.
8. Anticipated average amount of overtime/week _____
9. Gross **annual** earnings you anticipate for this employee for the next twelve months.
   (Gross amount including all tips, bonuses, overtime, commissions) $_____
10. Does this employee receive vacation with pay? o Yes o No
11. Does this employee receive sick leave pay? o Yes o No
12. If the employee's work is seasonal or sporadic, indicate lay-off periods: _____
13. Does this employee receive an earned income tax credit? o Yes o No
14. Additional Comments:_____

    _____

Completed by:
Name: _____
Title: _____
Signature: _____
Date: _____
Tele. No.: _____

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